Idaho Medicaid
Early Intervention Services

Reference Guide

For the Infant Toddler Program

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Idaho Medicaid Early Intervention
Quick Reference Sheet

	Service	Who?	New Billing?	When?	Guidelines
SCREENING	Pre-Eligibility Screening	EI Providers	Yes	Prior to enrollment	✓ Child Find Activities ✓ Screening Workshops ✓ Includes Hearing and Vision Screens
	Developmental Screening	EI Providers	Yes	Prior to enrollment or during enrollment when it is a stand-alone visit	✓ Screening tools must include one of the following: • Ages and Stages Questionnaire (ASQ) • Ages and Stages Questionnaire - 3rd Edition (ASQ-3) • Battelle Developmental Inventory Screening Tool (BDI-ST) • Bayley Infant Neuro-developmental Screen (BINS) • Brigance Screens-II • Child Development Inventory (CDI) • Infant Development Inventory • Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8 • Parent's Evaluation of Developmental Status - Dev Milestones
EVALUATION	PT, OT, SLP Evaluation	OT, PT, SLP	No	During enrollment	✓ Discipline-specific evaluation to assist with plan development
	Developmental Evaluation	EI Providers	Yes	Prior to enrollment or during enrollment to determine a child's initial and ongoing eligibility	✓ Must use a standardized instrument ✓ Requires written report/recommendations for treatment ✓ Instrument must evaluate the child's level of functioning in the 5 developmental areas: • Cognitive development • Physical development, including vision/hearing • Communication development • Social or emotional development • Adaptive development
	Early Intervention Assessment	EI Providers	Yes	During enrollment when it is a stand-alone visit to identify a child's	✓ Can use a non-standardized instrument ✓ Initial and ongoing assessment in one or more developmental area (includes hearing and vision assessments) ✓ Early childhood outcomes assessment or determination

Updated 9/10/18

				current needs and level of functioning	

	Service	Who?	New Billing?	When?	Guidelines
INTERVENTION	Early Intervention	EI Providers	Yes	During enrollment	✓ Individualized education, training, and consultation delivered to the child and family in their natural environment
	Joint Visit	EI Providers	Yes	During enrollment	✓ Two EI providers attend a home visit at the same time to collaborate with the child and family ✓ Visit must be at least 30 minutes in duration ✓ Secondary Service Provider is the joint visitor
MDT	Teaming	EI Providers	Yes	During enrollment	✓ Two or more EI providers meet to review, integrate, and plan for the child's early intervention services ✓ Does <u>not</u> include IFSP Development

IDEA, Part C Services

IDEA Part C services includes the following early intervention services:

- Assistive Technology Device
- Assistive Technology Service
- Audiology
- Family Training, Counseling, and Home Visits
- Health Services
- Medical Services Only for Diagnostic or Evaluation Purposes
- Nursing Services
- Nutrition Services
- Occupational Therapy
- Physical Therapy
- Psychological Services
- Service Coordination
- Service Coordination Services
- Sign Language and Cued Language Services
- Social Work Services
- Special Instruction
- Speech/Language Pathology
- Transportation and Related Costs
- Vision Services

Service Coordination

For children on Medicaid, some IDEA Part C services may be reimbursed in ways other than the Early Intervention fee schedule. IDEA Part C services reimbursed in ways other than the early intervention fee schedule include:

Service Coordination/Infant Toddler Program

Service Coordination is provided to all families in ITP. Service Coordination services refer to activities carried out by a Service Coordinator that assist and enable a child and family to receive the multidisciplinary evaluation, IFSP development, rights, procedural safeguards, and services that are authorized to be provided by the ITP. The Service Coordinator is responsible for coordinating all services across agency lines and serving as a single point of contact in helping families obtain needed services and assistance.

Service Coordination for Medicaid participants is reimbursed through Medicaid administrative claiming as authorized in section 1903(a)(7) of the Social Security Act. Administrative expenditures necessary for the administration of the state plan must not duplicate payment for activities that are already being offered or should be provided by other entities or paid through other programs. Therefore, service coordination must not be reimbursed through the early intervention fee for services.

Pre-Eligibility Screening

Code: T1023 TL **Unit:** 1 screen **Telehealth:** No

Definition

The purpose of the pre-eligibility screening is to determine the appropriateness of a child's participation in ITP. Administration of a screening instrument is the first step in detecting potential delays or impairments in any area of a child's development. Screening informs the need to refer the child for a more in-depth eligibility evaluation. The screening can be delivered through a mail-in questionnaire format, in person, or over the phone.

Qualified Providers

Providers of pre-eligibility screening are early intervention providers from Reimbursement Category 1 and/or Category 2 including:

- developmental therapists, marriage and family therapists, professional counselors, orientation/mobility specialists, vision specialist, registered dieticians, licensed practical nurses, and teachers for the hearing and visually impaired
- physical therapists, occupational therapists, speech-language pathologists, audiologists, nurses (registered nurses or nurse practitioners), psychologists, optometrists, pediatricians/physicians, and physician assistants

Physician Recommendation

A physician recommendation is not required.

Third Party Liability

Third party liability does not apply to EPSDT screening and diagnostic services.

Documentation

This service will be documented through the completion of a Continuing Service Record, and by including the screener results in the child's file in ITPKIDS.

Limitations

Children receiving this screening are not enrolled in ITP.

Developmental Screening

Code: 96110 TL **Unit:** 1 screen **Telehealth:** No

Definition

The purpose of developmental screening is to determine the appropriateness of a child's participation in ITP, or if additional ongoing assessment is needed for children enrolled in ITP. This screening occurs prior to enrollment or throughout service delivery. The screening can be delivered through a mail-in questionnaire format, in person, or over the phone.

Qualified Providers

Providers of developmental screening are early intervention providers from Reimbursement Category 1 and/or Category 2 including:

- developmental therapists, marriage and family therapists, professional counselors, orientation/mobility specialists, vision specialist, registered dieticians, licensed practical nurses, and teachers for the hearing and visually impaired
- physical therapists, occupational therapists, speech-language pathologists, audiologists, nurses (registered nurses or nurse practitioners), psychologists, optometrists, pediatricians/physicians, and physician assistants

Physician Recommendation

A physician recommendation is not required.

Third Party Liability

Third party liability does not apply to EPSDT screening and diagnostic services.

Documentation

This service will be documented through the completion of a Continuing Service Record, and by including the screener results in the child's file in ITPKIDS.

Limitations

Developmental Screening is billed anytime the following screeners are used:

- Ages and Stages Questionnaire (ASQ)
- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Battelle Developmental Inventory Screening Tool (BDI-ST)
- Bayley Infant Neuro-developmental Screen (BINS)
- Brigance Screens-II
- Child Development Inventory (CDI)
- Infant Development Inventory
- Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
- Parent's Evaluation of Developmental Status - Dev Milestones

PT, OT, SLP Evaluation

Code: 92521 TL, 92522 TL, 92626 TL, 92523 TL, 92523 TL UC, 92610 TL, 97161 TL, 97162 TL, 97163 TL, 97164 TL, 97165 TL, 97166 TL, 97167 TL, 97168 TL

Unit: 1 assessment

Telehealth: No

Rate: See Medicaid Independent Therapy fee schedule

Qualified Providers
Physical therapists, occupational therapists and speech-language pathologists

Physician Recommendation
A physician recommendation is required for PT, OT, SLP Evaluations.

Third Party Liability
Third party liability does not apply to EPSDT screening and diagnostic services.

Documentation
This service will be documented through the completion of a Continuing Service Record, and by including the evaluation results in the child's file in ITPKIDS. A full written report is not required.

**For Speech-Language Pathology and Audiology evaluation requirements, refer to the Speech, Language, and Hearing section of the Idaho Medicaid Handbook.

**For Occupational Therapy and Physical Therapy evaluation requirements, refer to the Respiratory, Developmental, Rehab, Restorative Services section of the Idaho Medicaid Handbook.

Developmental Evaluation

Code: 96111 TL **Unit:** 1 evaluation **Telehealth:** No

Definition
A developmental evaluation is used by the multi-disciplinary team when necessary to determine a child's initial and continuing eligibility for ITP.

This evaluation must evaluate the child's level of functioning in each of the following developmental areas, and identifies the services necessary to address developmental needs in those areas:

- Cognitive development
- Physical development, including vision and hearing
- Communication development
- Social or emotional development
- Adaptive development

Qualified Providers
Providers of developmental evaluation are early intervention providers from Reimbursement Category 1 and/or Category 2 including:

- developmental therapists, marriage and family therapists, professional counselors, orientation/mobility specialists, vision specialist, registered dieticians, licensed practical nurses, and teachers for the hearing and visually impaired
- physical therapists, occupational therapists, speech-language pathologists, audiologists, nurses (registered nurses or nurse practitioners), psychologists, optometrists, pediatricians/physicians, and physician assistants

Physician Recommendation
A physician recommendation is required for the Developmental Evaluation.

Third Party Liability
Third party liability does not apply to EPSDT screening and diagnostic services.

Documentation
This service will be documented through the completion of a Continuing Service Record and by including a completed evaluation report in ITPKIDS. All evaluation reports completed for eligibility should be provided to the child's family, and the child's physician.
An evaluation report must include, but is not limited to, the following components:

- Eligibility comments,
- Summary of findings, including information contributed by the family/caregivers regarding the child and their family,
- Analysis and interpretation of the child's performance,
- The child's unique strengths and needs and recommendations to meet those needs, and
- Recommendations for treatment.

Limitations

Evaluations of each child must be conducted by personnel trained to utilize appropriate methods and procedures, be based on informed clinical opinion, and be age appropriate, reliable, and valid. The Developmental Evaluation must be completed in person and should not be used for ongoing assessment for service delivery. The evaluation includes the following:

- Administering a standardized evaluation instrument;
- Taking the child's history (including interviewing the parent);
- Reviewing pertinent records related to the child's current health status and medical history;
- Gathering information from other sources such as family members, care-givers, medical providers, social workers, and educators, if necessary, to understand the full scope of the child's unique strengths and needs.

Early Intervention Assessment

Code: H2000 TL **Unit:** 15 minutes **Telehealth:** No

Definition

Early intervention assessment involves activities, observations and the administration of instruments and tools to identify current needs and functioning of the child within their natural environment. These assessment activities may occur prior to and after a child has an IFSP in place. This code may be used when the following assessment activities are completed:

- Initial or ongoing assessment of the child's level of functioning in one or more developmental areas including cognitive development, physical development (including vision and hearing), communication development, social or emotional development, and adaptive development
- Annual child assessment
- Early childhood outcomes assessment and/or determination

Reimbursable activities for early intervention assessment include observation, interpretation, scoring, and write up time for instruments and tools utilized. Assessment instruments and procedures can be either standardized or non-standardized.

Qualified Providers

Providers of early intervention assessment are early intervention providers from Reimbursement Category 1 and/or Category 2 including:

- developmental therapists, marriage and family therapists, professional counselors, orientation/mobility specialists, vision specialist, registered dieticians, licensed practical nurses, and teachers for the hearing and visually impaired
- physical therapists, occupational therapists, speech-language pathologists, audiologists, nurses (registered nurses or nurse practitioners), psychologists, optometrists, pediatricians/physicians, and physician assistants

Physician Recommendation

A physician recommendation is required for the Early Intervention Assessment.

Third Party Liability

Third party liability does not apply to EPSDT screening and diagnostic services.

Documentation

This service will be documented through the completion of a Continuing Service Record, and by including assessment results in the child’s ITPKIDS file. A full written report is not required.

Limitations

Initial assessment results should include a recommendation for early intervention treatment.

Early Intervention

Code: T1027 TL; S5110 TL **Unit:** 15 minutes **Telehealth:** Yes

Definition

Early intervention involves individualized education, training and consultation provided to the child/family/caregivers to promote the child's age appropriate growth and development as identified in the IFSP. Providers of early intervention assist caregivers to recognize the learning opportunities in the family's daily activities, and how to apply intervention strategies so that families are supporting change between visits. Eligible children and their families receive early intervention services to support progress toward outcomes developed in the child's IFSP.

Qualified Providers

Providers of early intervention are early intervention providers from Reimbursement Category 1 and/or Category 2 including:

- developmental therapists, marriage and family therapists, professional counselors, orientation/mobility specialists, vision specialist, registered dieticians, licensed practical nurses, and teachers for the hearing and visually impaired
- physical therapists, occupational therapists, speech-language pathologists, audiologists, nurses (registered nurses or nurse practitioners), psychologists, optometrists, pediatricians/physicians, and physician assistants

Physician Recommendation

A physician recommendation is required for Early Intervention.

Third Party Liability

If the child has insurance other than Medicaid, the Infant Toddler Program must bill the third-party insurance and complete all the billing requirements for that carrier first, and then bill Medicaid.

Documentation

This service will be documented through the completion of a Continuing Service Record.

Limitations

The child must be present for services, and the services must be delivered in accordance to the IFSP (e.g. duration, length, frequency, location, IFSP date range). Inclusion and participation of the child and family/caregivers is required for billable intervention.

Joint Visit

Code: 99366 TL **Unit:** 30 minutes **Telehealth:** Yes

Definition

A joint visit is a home visit in which the secondary service provider (SSP) accompanies the primary service provider (PSP) for the purpose of supporting the PSP, the child's care providers, and the child. This service is used when two interventionists meet with the caregiver and child during a visit to identify and integrate strategies that support the child's progress toward established outcomes.

Qualified Providers

Providers of joint visits are early intervention providers from Reimbursement Category 1 and/or Category 2 including:

- developmental therapists, marriage and family therapists, professional counselors, orientation/mobility specialists, vision specialist, registered dieticians, licensed practical nurses, and teachers for the hearing and visually impaired
- physical therapists, occupational therapists, speech-language pathologists, audiologists, nurses (registered nurses or nurse practitioners), psychologists, optometrists, pediatricians/physicians, and physician assistants

Physician Recommendation

A physician recommendation is required for Joint Visits.

Third Party Liability

If the child has insurance other than Medicaid, the Infant Toddler Program must bill the third-party insurance and complete all the billing requirements for that carrier first, and then bill Medicaid.

Documentation

The PSP bills Early Intervention and the SSP bills Joint Visit. Documentation at the time of service is completed by the PSP with a Joint Plan. The Joint Visit will be documented by the Secondary Service Provider (SSP) through the completion of a Continuing Service Record (CSR).

Limitations

To be considered billable, both early intervention providers must be an authorized care provider on the IFSP and be present for the service. Joint Visits must be planned with other MDT members/service providers before the joint visit is conducted and be at least 30 minutes in duration.

Teaming

Code: T1024 TL **Unit:** 1 meeting **Telehealth:** No

Definition

Teaming occurs when there is coordination of two or more early intervention providers for the purpose of reviewing, integrating, and planning for a child's effective early intervention.

Qualified Providers

Providers of Teaming are early intervention providers from Reimbursement Category 1 and/or Category 2 including:

- developmental therapists, marriage and family therapists, professional counselors, orientation/mobility specialists, vision specialist, registered dieticians, licensed practical nurses, and teachers for the visually impaired
- physical therapists, occupational therapists, speech-language pathologists, audiologists, nurses (registered nurses or nurse practitioners), psychologists, optometrists, pediatricians/physicians, and physician assistants.

Physician Recommendation

A physician recommendation is required for Teaming.

Third Party Liability

If the child has insurance other than Medicaid, the Infant Toddler Program must bill the third-party insurance and complete all the billing requirements for that carrier first, and then bill Medicaid.

Documentation

This service will be documented by the Primary Service Provider (PSP) through the completion of a Continuing Service Record. If the PSP is not present, a secondary service provider may document the service.

Limitations

To be considered billable, at least two or more early intervention providers from Reimbursement Category 1 and/or Category 2 must be present. Meetings must be a minimum of 15 minutes and may be with or without the family present. IFSP development is not a teaming activity and should not be billed as such.

Joint Plan

Name: _____

Date: _____/_____/_____ Start Time/ _____AM/PM End Time: AM/PM

Review: What has happened since our last visit?

Recap of today's visit: What outcome was worked on and what was the response?

Next steps: What would you like to focus on **between** now and our next visit? Who will do what?

The focus of our **next** visit will be:

Date: Time: Location:

☐ Early Intervention ☐ Joint Visit

Early Intervention Provider signature Credentials

Early Intervention Joint visitor signature Credentials

Joint Plan

Name: _____

Date: _____/_____/_____ Start Time/ _____AM/PM End Time: AM/PM

Review: What has happened since our last visit?

Recap of today's visit: What outcome was worked on and what was the response?

Next steps: What would you like to focus on **between** now and our next visit? Who will do what?

The focus of our **next** visit will be:

Date: Time: Location:

☐ Early Intervention ☐ Joint Visit

Early Intervention Provider signature Credentials

Early Intervention Joint visitor signature Credentials

Idaho Infant Toddler Program

Individualized Family Service Plan - Part 1
Assessment and Planning Tool

The mission of the Idaho Infant Toddler Program is to provide quality early intervention support and services to enhance the capacity of families to meet the needs of children birth to three years of age who have developmental delays or disabilities.

We would like to begin by gathering some information about your child and family. This information will be shared with your early intervention team and will help in making decisions about eligibility and recommendations for possible services.

If your child is found eligible, this information will be used to develop the Individualized Family Service Plan (IFSP). This information also serves as the Family Assessment.

Demographic Information

Child's Name: _____ Date of Birth: _____ ☐ Female ☐ Male

Parent/Guardian: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ (w) ▫ (h) ▫ (c) ▫ Email Address: _____

Phone Number: _____ (w) ▫ (h) ▫ (c) ▫ _____ (w) ▫ (h) ▫ (c) ▫

2nd Contact: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ (w) ▫ (h) ▫ (c) ▫ Email Address: _____

Family's Primary Language: _____ Child's Race/Ethnicity: _____

Additional Info (e.g. prefer text, directions):

Health Information

Primary Care Physician: _____ Medicaid #: _____

Clinic Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ FAX: _____ Email Address: _____

Healthy Connections? Y N Insurance Company: _____ Policy #: _____

Service Coordination Information

Service Coordinator: _____ Agency: _____

Agency Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ FAX: _____ Email Address: _____

☐ Intake Only ☐ Initial IFSP ☐ 6 Month Review ☐ Annual IFSP Date of Original IFSP: _____

Date Completed: _____

Updated 9/10/18

Child's Name: DOB 20 IFSP Start Date:

Idaho Infant Toddler Program

Individualized Family Service Plan – Part 2

Plan Development

The development of an Individualized Family Service Plan (IFSP) is a process in which you and your early intervention team work together as partners. Together we will create a plan of action based on your family and child's needs and assessments to support your family in meeting your child's developmental needs.

Child/Family Photo

Specialists from a variety of backgrounds and qualifications are available to work with and support your family in promoting your child's development and learning. The following people are members of your early intervention team.

Name	Role	Agency/Address	Phone	Email
	Parent			
	Service Coordinator			

Early Intervention Team Photos (Optional)

☐ Initial IFSP ☐ Annual IFSP Date of Original IFSP: _____

Updated 9/10/18

Child's Name: DOB 20 IFSP Start Date:

Summary of Services

☐ Physician's Recommendation Only **Service Coordinator Signature:** _____
Date: _____

Early Intervention Services & Intensity (individual/group)	**Person(s)/ Agency(ies) Responsible**	**Start Date End Date** (Duration)	**Length** (time service provided) **Frequency** (# of days or sessions) **Method** (how service provided) **Location** (place of service)	**Funding Source** If Medicaid, MID #	***NE** Y or N
***NE:** If No, please complete the Natural Environment Justification page.					
Other services the child or family needs or is receiving through other sources that are not required or funded by the Infant Toddler Program (Part C of IDEA)					
Diagnosis Description:					
ICD-10 Code:					

Consent by Parents/Guardians for Provision of Services

I participated in the development of this plan. I understand that:

- With receipt of my Procedural Safeguards, this plan serves as Prior Written Notice for evaluation, placement, and/or the provision of listed services.
- If there is an increase in the frequency, length, duration, or intensity of services, a copy of the Infant Toddler Program's System of Payment policy will be provided and reviewed with me.
- The provision of listed services includes the completion of ongoing assessments.

I give informed consent for this Individualized Family Service Plan (IFSP) to be carried out as written.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Physician Recommendation and Financial Authorization

I have reviewed the above health-related services and certify that they are medically necessary and that continued care is necessary for the duration of services listed in this Individualized Family Service Plan.

*Physician Signature: _____ Date: _____

Physician Name (Printed or Typed): _____ Clinic: _____

I have reviewed and authorize payment for the above listed early intervention services as defined in the Individuals with Disabilities Education Act (IDEA) Reauthorization, Public Law 108-446, Part C.

Lead Agency Authorizing Signature: _____ Date: _____

Date of IFSP: _____ ☐ Initial ☐ Annual ☐ Addendum / Date: _____
6 Month review _____ Reason for Addendum

Child's Name: DOB 20 IFSP Start Date:

Summary of Services

☐ Physician's Recommendation Only **Service Coordinator Signature:** _____ **Date:** _____

Early Intervention Services & Intensity (individual/group)	**Person(s)/ Agency(ies) Responsible**	**Start Date End Date** (Duration)	**Length** (time service provided) **Frequency** (# of days or sessions) **Method** (how service provided) **Location** (place of service)	**Funding Source** If Medicaid, MID #	***NE** Y or N
Service Coordination	Mickey Mouse, Infant Toddler Program	7/1/18 6/30/19	20 sessions for 15 minutes each, direct, in the home	Part C	Y
Early Intervention by DS	Donald Duck, Infant Toddler Program	7/10/18 1/10/19	12 visits for 60 minutes each, direct, in the home	Medicaid	Y
Joint Visit by SLP	Minnie Mouse, Infant Toddler Program	7/10/18 10/10/18	3 visits, 60 minutes each, direct, in the home	Medicaid	Y
Teaming	MDT, Infant Toddler Program	7/1/18 6/30/19	4 times, 30 minutes, face-to-face, office	Medicaid	Y
***NE:** If No, please complete the Natural Environment Justification page.					
Other services the child or family needs or is receiving through other sources that are not required or funded by the Infant Toddler Program (Part C of IDEA)					
Diagnosis Description:					
ICD-10 Code:					

Consent by Parents/Guardians for Provision of Services

I participated in the development of this plan. I understand that:

- With receipt of my Procedural Safeguards, this plan serves as Prior Written Notice for evaluation, placement, and/or the provision of listed services.
- If there is an increase in the frequency, length, duration, or intensity of services, a copy of the Infant Toddler Program's System of Payment policy will be provided and reviewed with me.
- The provision of listed services includes the completion of ongoing assessments.

I give informed consent for this Individualized Family Service Plan (IFSP) to be carried out as written.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Physician Recommendation and Financial Authorization

I have reviewed the above health-related services and certify that they are medically necessary and that continued care is necessary for the duration of services listed in this Individualized Family Service Plan.

*Physician Signature: _____ Date: _____

Physician Name (Printed or Typed): _____ Clinic: _____

I have reviewed and authorize payment for the above listed early intervention services as defined in the Individuals with Disabilities Education Act (IDEA) Reauthorization, Public Law 108-446, Part C.

Lead Agency Authorizing Signature: _____ Date: _____

Date of IFSP: _____ ☐ Initial ☐ Annual ☐ Addendum / Date: _____

6 Month review _____ Reason for Addendum

Date Completed: _____

Child's Name: DOB 20 IFSP Start Date:

Summary of Services

☐ Physician's Recommendation Only **Service Coordinator Signature:** _____ **Date:** _____

Early Intervention Services & Intensity (individual/group)	**Person(s)/ Agency(ies) Responsible**	**Start Date End Date** (Duration)	**Length** (time service provided) **Frequency** (# of days or sessions) **Method** (how service provided) **Location** (place of service)	**Funding Source** If Medicaid, MID #	***NE** Y or N
Service Coordination	John Doe, Infant Toddler Program	7/1/18 6/30/19	20 sessions for 15 minutes each, direct, in the home	Part C, Ins.	Y
Early Intervention by Clinician	Happy Clinician, Infant Toddler Program	7/10/18 1/10/19	6 visits for 60 minutes each, direct, in the home	Part C, Ins.	Y
Teaming	MDT, Infant Toddler Program	7/1/18 6/30/19	4 times, 30 minutes, face-to-face, office	Part C, Ins.	Y
Hearing – Special Instruction	Donald Duck, IESDB	7/1/18 1/10/19	6 visits for 60 minutes each, direct, in the home	Part C, Ins.	Y
***NE:** If No, please complete the Natural Environment Justification page.					
Other services the child or family needs or is receiving through other sources that are not required or funded by the Infant Toddler Program (Part C of IDEA)					
Diagnosis Description:					
ICD-10 Code:					

Consent by Parents/Guardians for Provision of Services

I participated in the development of this plan. I understand that:

- With receipt of my Procedural Safeguards, this plan serves as Prior Written Notice for evaluation, placement, and/or the provision of listed services.
- If there is an increase in the frequency, length, duration, or intensity of services, a copy of the Infant Toddler Program's System of Payment policy will be provided and reviewed with me.
- The provision of listed services includes the completion of ongoing assessments.

I give informed consent for this Individualized Family Service Plan (IFSP) to be carried out as written.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Physician Recommendation and Financial Authorization

I have reviewed the above health-related services and certify that they are medically necessary and that continued care is necessary for the duration of services listed in this Individualized Family Service Plan.

*Physician Signature: _____ Date: _____

Physician Name (Printed or Typed): _____ Clinic: _____

I have reviewed and authorize payment for the above listed early intervention services as defined in the Individuals with Disabilities Education Act (IDEA) Reauthorization, Public Law 108-446, Part C.

Lead Agency Authorizing Signature: _____ Date: _____

Date of IFSP: _____ ☐ Initial ☐ Annual ☐ Addendum / Date: _____

6 Month review _____ Reason for Addendum

Child's Name: DOB 20 IFSP Start Date:

Summary of Services

☐ Physician's Recommendation Only **Service Coordinator Signature:** _____ **Date:** _____

Early Intervention Services & Intensity (individual/group)	**Person(s)/ Agency(ies) Responsible**	**Start Date End Date** (Duration)	**Length** (time service provided) **Frequency** (# of days or sessions) **Method** (how service provided) **Location** (place of service)	**Funding Source** If Medicaid, MID #	***NE** Y or N
Service Coordination	Lucky Lucy, Infant Toddler Program	7/1/18 6/30/19	20 sessions for 15 minutes each, direct, in the home	Part C, Ins.	Y
Early Intervention by PT	Early Riser, Infant Toddler Program	7/10/18 1/10/19	12 visits for 60 minutes each, direct, in the home	Medicaid, Ins.	Y
Joint Visit by DS	Sunny Suzie, Infant Toddler Program	7/10/18 10/10/18	3 visits, 60 minutes each, direct, in the home	Medicaid, Ins.	Y
Teaming	MDT, Infant Toddler Program	7/1/18 6/30/19	4 times, 30 minutes, face-to-face, office	Medicaid, Ins.	Y
Early Intervention Assessment	Sunny Suzie, Infant Toddler Program	7/25/18 8/10/18	1 visit, 60 minutes, direct, in the home	Medicaid, Ins.	Y
***NE:** If No, please complete the Natural Environment Justification page.					
Other services the child or family needs or is receiving through other sources that are not required or funded by the Infant Toddler Program (Part C of IDEA)					
Diagnosis Description:					
ICD-10 Code:					

Consent by Parents/Guardians for Provision of Services

I participated in the development of this plan. I understand that:

- With receipt of my Procedural Safeguards, this plan serves as Prior Written Notice for evaluation, placement, and/or the provision of listed services.
- If there is an increase in the frequency, length, duration, or intensity of services, a copy of the Infant Toddler Program's System of Payment policy will be provided and reviewed with me.
- The provision of listed services includes the completion of ongoing assessments.

I give informed consent for this Individualized Family Service Plan (IFSP) to be carried out as written.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Physician Recommendation and Financial Authorization

I have reviewed the above health-related services and certify that they are medically necessary and that continued care is necessary for the duration of services listed in this Individualized Family Service Plan.

*Physician Signature: _____ Date: _____

Physician Name (Printed or Typed): _____ Clinic: _____

I have reviewed and authorize payment for the above listed early intervention services as defined in the Individuals with Disabilities Education Act (IDEA) Reauthorization, Public Law 108-446, Part C.

Lead Agency Authorizing Signature: _____ Date: _____

Child's Name: DOB 20 IFSP Start Date:

Summary of Services

☐ Physician's Recommendation Only **Service Coordinator Signature:** _____
Date: _____

Early Intervention Services & Intensity (individual/group)	**Person(s)/ Agency(ies) Responsible**	**Start Date End Date** (Duration)	**Length** (time service provided) **Frequency** (# of days or sessions) **Method** (how service provided) **Location** (place of service)	**Funding Source** If Medicaid, MID #	***NE** Y or N
Service Coordination	Lucky Lucy, Infant Toddler Program	7/1/18 6/30/19	20 sessions for 15 minutes each, direct, in the home	Part C	Y
Early Intervention by OT	Early Riser, Infant Toddler Program	7/10/18 1/10/19	12 visits for 60 minutes each, direct, in the home	Medicaid	Y
Joint Visit by Nutritionist	Cookie Monster, Infant Toddler Program	7/10/18 10/10/18	2 visits, 60 minutes each, direct, in the home	Medicaid	Y
Teaming	MDT, Infant Toddler Program	7/1/18 6/30/19	4 times, 30 minutes, face-to-face, office	Medicaid	Y
***NE:** If No, please complete the Natural Environment Justification page.					
Other services the child or family needs or is receiving through other sources that are not required or funded by the Infant Toddler Program (Part C of IDEA)					
Diagnosis Description:					
ICD-10 Code:					

Consent by Parents/Guardians for Provision of Services

I participated in the development of this plan. I understand that:

- With receipt of my Procedural Safeguards, this plan serves as Prior Written Notice for evaluation, placement, and/or the provision of listed services.
- If there is an increase in the frequency, length, duration, or intensity of services, a copy of the Infant Toddler Program's System of Payment policy will be provided and reviewed with me.
- The provision of listed services includes the completion of ongoing assessments.

I give informed consent for this Individualized Family Service Plan (IFSP) to be carried out as written.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Physician Recommendation and Financial Authorization

I have reviewed the above health-related services and certify that they are medically necessary and that continued care is necessary for the duration of services listed in this Individualized Family Service Plan.

*Physician Signature: _____ Date: _____

Physician Name (Printed or Typed): _____ Clinic: _____

I have reviewed and authorize payment for the above listed early intervention services as defined in the Individuals with Disabilities Education Act (IDEA) Reauthorization, Public Law 108-446, Part C.

Lead Agency Authorizing Signature: _____ Date: _____

Date of IFSP: _____ ☐ Initial ☐ Annual ☐ Addendum / Date: _____
6 Month review _____ Reason for Addendum

Date Completed: _____

PHYSICIAN'S RECOMMENDATION FOR EVALUATION(S)

Patient Name: **Today's Date:**

Patient's DOB: **Patient's Diagnosis:**

Is Referred to:

Name of Provider: Infant Toddler Program

Attention Service Coordinator:

Address:

Phone: **FAX:**

Requesting authorization for the following medically necessary early intervention evaluations:

- Occupational Therapy
- Physical Therapy
- Audiology
- Speech/Language
- Oral and Pharyngeal Swallowing Function
- Developmental
- Other (Please list here):

Anticipated Outcome:

Referring Physician Information:

Physician Organization Name:

Physician's Printed Name:

Phone: **FAX:**

Physician's Signature _____ **Date** _____

***DURATION OF PHYSICIAN'S RECOMMENDATION FOR EVALUATION(S):**

* Recommendation for evaluation(s) must be updated yearly from the date of the physician's signature.
A copy of all evaluation reports and Individual Family Service Plan (IFSP) Summary of Services page will be sent to Physician.

Eligibility Reverification Tips

In most cases, the Multi-Disciplinary Team (MDT) will know the child's current functioning or medical status to document and determine annual eligibility reverification. In these instances, a team can determine that a child continues to meet ITP eligibility criteria without an MDT eligibility review of the child's records or re-evaluation (refer to MDT eligibility review below). Examples of these cases include:

- Limited or no growth in development that **does not** impact current ITP eligibility.
- Recent screener/ongoing assessment demonstrates increased growth in development but **does not** impact current ITP eligibility.
- Established medical condition that **does not** warrant a change in ITP eligibility. Examples include Down Syndrome, Spinabifida, Cerebral Palsy, Autism, etc.

If the MDT cannot definitively reverify eligibility without taking additional actions, an MDT eligibility review is required. In this instance, the multi-disciplinary team must decide the action(s) necessary to reverify eligibility. These actions could include but are not limited to:

- Review of pertinent records/information including but not limited to the IFSP, CSRs, existing medical records, parent feedback, existing evaluations, existing ongoing assessments and/or screeners.
- Completion of a screener or assessment.
- Completion of an evaluation that looks at all developmental domains resulting in a standard deviation, percentile, or age equivalency scores in accordance with ITP eligibility.

MDT eligibility review examples:

- Medical Status Change
  - Change in current medical status (e.g. chronic otitis media, torticollis, cleft lip and palate) that has been resolved and could change program eligibility.
  - New medical diagnosis that may warrant a change in program eligibility category (e.g. DD (speech delay) to EMC (autism, hearing loss, apraxia, etc.), ICO (motor delay) to EMC (cerebral palsy)).
  - EMC eligibility based on newborn code (e.g. prematurity, small for gestational age, low birth weight, etc.)
- Developmental Status Change
  - Significant growth in development that could impact program eligibility.
  - A moderate growth in development, however development is still delayed compared to typically developing peers that may impact program eligibility.
  - Child currently eligible under Informed Clinical Opinion.

NOTE: When the MDT decides on which action(s) to take to reverify eligibility, keep in mind that denials of ITP eligibility can only be made using assessments or evaluations which include all developmental domains that yield standard deviation, percentile, and/or age equivalency scores.

Updated 9/10/18

IDAHO INFANT TODDLER PROGRAM
ELIGIBILITY & ANNUAL REVERIFICATION CHECKLIST

Name: _____ **Date of Birth or Date of Expected Birth:** _____

Meets ITP Eligibility: ☐ **Yes** ☐ **No** ☐ **Initial Eligibility** ☐ **Annual Reverification** ☐ **Other***

Date of Determination: _____ **Service Coordinator:** _____

Infant Toddler Program participants must meet one of three eligibility categories listed below, as defined in the *Idaho Infant Toddler Program eManual, "Eligibility"* section. Documentation must be obtained to support eligibility.

ELIGIBILITY CATEGORY	DUE TO… (must select one for the category identified)
☐ **DEVELOPMENTAL DELAY** *Children with or without an established diagnosis who by assessment measurements have fallen significantly behind developmental norms in one or more of the five functional areas.* **OR**	☐ 30% below age norm, or ☐ exhibits a six-month delay, whichever is less, adjusted for prematurity up to 24 months in one (1) or more of the functional areas as indicated below: **OR** ☐ Demonstrates at least two (2) standard deviations below the mean in one (1) of the functional areas as indicated below: **OR** ☐ Demonstrates at least one and a half (1.5) standard deviations below the mean in two (2) or more of the functional areas as indicated below: **FUNCTIONAL AREAS - Check to indicate area(s) of delay as defined above:** ☐ Cognitive ☐ Social/Emotional ☐ Adaptive ☐ Physical (☐ fine and/or ☐ gross motor and/or ☐ sensory) ☐ Communication (☐ receptive and/or ☐ expressive) Sources and dates of supporting information: _____ _____ **Recommended ICD-10 Diagnosis Code(s):** _____
☐ **ESTABLISHED MEDICAL CONDITION** *Refer to "Idaho Infant Toddler Eligibility Criteria" in the ITP eManual* **OR**	☐ Confirmed sensory impairment must document that child has <u>at least one</u> of these conditions: ☐ Deaf-Blind ☐ Hearing Impaired: must document that child has <u>at least one</u> of these conditions: Hard of Hearing, Deaf, Hearing Loss, Hearing Impairment, Chronic Otitis Media, chronic allergies, and/or eardrum perforations ☐ Visually Impaired ☐ Physical Impairment (Orthopedic) ☐ Neurological/Physiological Impairments/Developmental Disabilities ☐ Interactive Disorders ☐ Medically Fragile Infant ☐ Prematurity Plus Significant Environmental Risk ☐ Other Health Impairments _____ Sources and dates of supporting information:_____ _____
☐ **INFORMED CLINICAL OPINION** *Refer to "Idaho Infant Toddler Eligibility Criteria" in the ITP eManual*	Factors influencing the decision: _____ _____ Sources and dates of supporting information: _____ _____

Early Intervention Provider Signature: _____
Date: _____

*Other – Eligibilty reverification occurring at times other than initial eligibility or annual reverification based on team.